

(Please attach forms if room is insufficient here)

School\_\_\_\_\_

Staff Identification	
Name _____	Date of Birth_____
Parent Name _____	Emergency Telephone No._____
Hospital Emergency Room _____	Telephone No._____
Ambulance Service _____	Telephone No._____
School Nurse _____	Telephone No._____
Physician _____	Telephone No._____
Health Care Coordinator/Facilitator at School _____	Extension_____
Direct Care Staff _____	Extension _____
Background Information	
Nursing Assessment	
Brief Medical History/Specific Health Care	
Psychosocial Concerns	
Child and Family Strengths	
Academic/Achievement Profile	
Goals and Actions	
Procedures and Interventions	
Child Specific Techniques	

Medications
Diet
Transportation
Classroom Modifications
Equipment and Supplies
Training, Education (staff, CPR, skills checklist), (peers, students)
Safety Measures
<b>Contingencies</b>
Emergency Plan (If you see this...do this)
Substitute/Back up Staff (when primary staff not available)
Possible Problems to be Expected
<b>Authorizations</b>
Parent Signature _____ Date_____
Health Care Coordinator at School _____ Date _____
Physician: order for medication/specialized procedure (if pertinent). Initial if MD has approved. _____
_____
School Nurse _____ Date_____
Effective Date _____ Date Health Care Checklist Completed _____
IEP if Appropriate _____ Date_____ Skills checklist for whom? _____ Date_____

April 1991